VOL. 14, NO. 4 NOV.-DEC., 1964

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

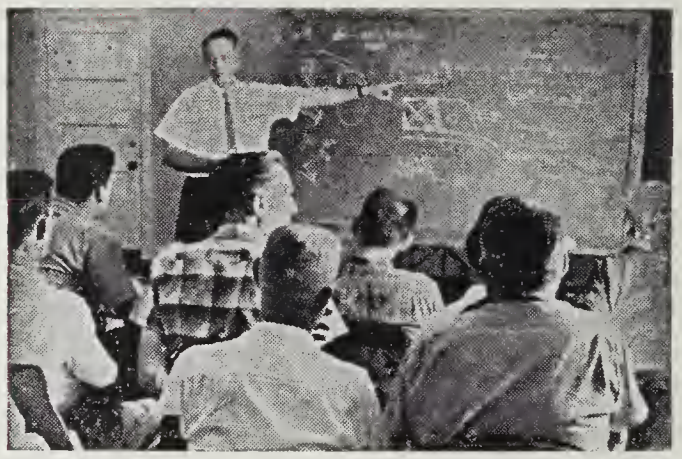
EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The Center is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Department of Mental Health. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay if the patient is able to pay.



Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the professional staff, educational films, individual consultations with staff members, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the medical director, one other physician, a psychiatric social worker, psychologist, chaplain and admitting officer, vocational rehabilitation counselor, activities director, and a full attendant staff.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment in response to written or telephone request to the Medical Director of the Center, 406 Central Avenue, Butner, N. C., expressing voluntary desire for treatment. All appointments must be confirmed by mail and should preferably be made by the patient's physician or by other professional personnel in the patient's community, for example, alcoholism information center personnel.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician, are necessary.

3. A fee of $75, in cash or certified check, must be paid upon admission if the patient is able.

4. Sign a letter-statement requesting voluntary admission at the time of admission.

It is especially important that patients applying for admission have a thorough medical examination and be in good physical condition at the time of their admission. The Center is not a hospital or a sobering up facility and patients desiring admission should have been sober for at least seventy-two hours and should not be exhibiting withdrawal symptoms. There are no facilities provided at the Center for the treatment of physical illness. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

Wednesday, Thursday and Friday during the morning and afternoon. Patients may have visitors after they've been at the Center for 2 weeks. Visiting hours are from 1:00-4:00 P.M. on Saturday and Sunday.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA DEPARTMENT OF MENTAL HEALTH

NORBERT L. KELLY, Ph.D.
Associate Director

NORMAN DESROSIERS, M.D.
Medical Director

GEORGE H. ADAMS
Educational Director

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RALEIGH, N. C.

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Write: INVENTORY, P. O. Box 9494, Raleigh, North Carolina.

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UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912

My Children Have Been Helped

By The Wife Of An Alcoholic

Counseling the children of alcoholics could play an important part in prevention of alcoholism.

IN the past few years, much progress has been made in the treatment of alcoholics and in the counseling of their wives. But little seems to be happening in the counseling of young people who have grown up in the alcoholic's home with the disturbing influences that accompany living with alcoholism.

I discovered after doing much reading on the subject that the history of alcoholism in my family and in my husband's family is not unique—that many alcoholics and their wives are the children of alcoholics. Surely this suggests that counseling for the children of alcoholics could be an important form of preventive medicine. (All alcoholics do not come from homes where alcoholism was a problem, but enough of them are products of such homes to make this important.)

I believe these children can be helped because my children have been helped. Let me tell you about my own experience.

A few years ago, we were well on the way to disaster. My husband's alcoholism was seemingly incurable. His attempts at treatment had not stopped his drinking. I was suffering with an ulcer, my older child was a chronic bedwetter and a very poor student, which irritated her teachers because all her tests showed her to be a potentially very bright girl who just wouldn't try; and my younger child was a frightened, insecure little girl who miraculously (perhaps because she was only six) seemed to be doing well at school. At home my younger daughter would simply run and hide when trouble started, which it so often did; and she began spending most of her time at someone else's house. She was much happier at school than she was at home, which may explain her success in school. If she had been older, her staying out could have become a serious problem.

Eventually, my older girl began to show signs of being deeply disturbed, signs which I could recognize even in my own confused emotional state. Two of my neighbors came to me and demanded that I keep her away from their children. She was a troublemaker who not only attacked the children, but was also deliberately doing things to get back at the parents who sent her away. I was called to the school because the principal had been called in to discipline her several times at the request of her teacher. She also went through periods when she would strike out at me and sometimes she would badly hurt her little sister. She was terrified of her father, and screamed to me when she went into her tantrums, "Why don't we go away from him; why do you let him treat you this way?" I would try to explain patiently that her father was sick, and couldn't help what was happening, but this didn't help her when the children taunted her about her father's drinking. She despised me for being a fool, and said so. She was then eleven years old.

I was becoming more and more confused, and couldn't cope with what was happening either to myself or to the children. The ulcer was getting worse, and my family doctor regularly advised me to seek help with my family problem. Finally, I took his advice and went

Reprinted by permission of the author and editor, this article was originally published in the Spring, 1964 issue of *Addictions*, a publication of the Alcoholism and Drug Research Foundation of Ontario, Canada.

to a Family Service Center. That was five years ago, and I call that the time of my life when I began growing up again—after standing still for many years. I cannot here go into the ways in which I was helped—the change in my life has been incredibly wonderful. This story is about my children, not about me.

Once I began getting some understanding about myself, and the things I was doing that made matters worse instead of better, the children became easier to handle. With the younger child, things seemed to improve quite soon, but with the older one I was still helpless. She was too disturbed. The trouble was so deeply rooted that she needed professional help.

Through the Family Service Center we found this help, and she began having regular appointments with a psychiatrist. All these developments did not, of course, happen as quickly as I can tell about them. By the time I found help for my daughter, she was thirteen years old and well on the way to becoming a serious problem to the community as well as to her family and to herself. As a result of her treatment and the counseling I received in trying to help her, she has leveled off and is now no more trouble than any normal teen-ager. She is a happy, popular girl, a good student, and rather than becoming a problem for the community, she has become an asset. Last summer, for instance, she was a counselor at a camp for underprivileged children. The fear of failure that had made her school work so poor is almost conquered. As a result, her grades are above average and she is seriously considering the possibility of attending a university.

My younger child, by the way, does not stay out any more. As a matter of fact, our home has become one of the most popular spots in the neighborhood because she now brings the kids here.

I should explain, of course, that because my husband could not stop drinking, and could make no progress with his problems, it was necessary for me to separate from him. One of the reasons I took so long in seeking help for my daughter was that I wrongly believed that once we were free from the daily problem of living with an alcoholic, all our difficulties would disappear. This was just not true. My daughter's problems were not solved automatically. As a matter of fact, her problems increased with only one parent. I would strongly urge that anyone who attempts to raise children alone after bringing them through serious family difficulties use the help the community has to offer.

To the agencies in the community, I would say: If you are treating alcoholics, find out the ages of their children and offer help to the older children who may already be seriously affected by the family problem. Perhaps this will help to prevent their coming to you a few years from now as alcoholics or their wives.

Alcoholics Anonymous has seen the need for helping young people, and has formed groups called Alateens. But some of the youngsters may be like some of their parents who were too sick for the kind of help A. A. can offer. They may need professional care.

Even if the parents are in treatment, how long will it take before this can filter through and make them better parents? Can a recovering alcoholic and a confused wife deal with a disturbed teenager? Not very likely, but a trained social worker or a psychiatrist may be able to help a great deal.

It worked for me and for my daughter, and I sincerely hope that treatment centers for alcoholism will soon see this vital need and offer help to the young people at the same time as they are treating the parents. They should not wait for the children to come to them. They should open the door and through parents, school guidance teachers, public health nurses, doctors, etc. invite them to come for help. They deserve a chance to rebuild their lives and they **do** need help.

Wealth of Information

We are always looking for current reference to the problem of alcoholism to use in our hopsital's special education sessions. The other day someone introduced me to your publication. I think it has a wealth of information that can be helpful to the therapist as well as to our staff doctors. It shall be added to our reference library.

S. Anna Rudovick
Director, Patient Services
John E. Runnells
Hospital For Chest Diseases
Berkeley Heights, N. J.

Practical Help

We use the material in *Inventory* for counseling and in group discussions of both alcoholics and non-alcoholics and we find the articles solid, informative and of great practical help for those caught up in the problem of alcoholism.

May I add a word of commendation for your whole rehabilitation program. Through the enlightened efforts of your department, North Carolina justly enjoys its high reputation in this difficult field.

Rev. Michael J. Dwyer
Duquesne University
Pittsburgh, Pa.

Basis For Group Discussion

This morning I found among the mail the July-August issue of *Inventory*. Two of the articles, "What We Say vs What We Do" and "Pastoral Counseling—the Focus of Community Concern"—seemed to be especially outstanding and thought-provoking. Would it be possible for you to send me another copy of this issue? I would like to use it as a basis for a group discussion program.

This is the first time I have seen *Inventory*. It certainly is most interesting—both in format and content. Congratulations!

Ruth Langley Hill
Salvation Army
Boston, Massachusetts

Caseworker Writes

I am a caseworker with the Gaston County Domestic Relations and Juvenile Court and am very interested in alcoholism. Would you please place my name on the mailing list for future copies of *Inventory* and other available material? Thank you.

Sue Dedmon
Shelby, N. C.

Help For Medical Students

Would it be possible for us to be put on your mailing list? We have the responsibility of helping the senior medical students from Marquette University understand the social and emotional factors involved in diagnosis and treatment of illness. Since alcoholism is frequently a problem for the patient or some member of his family, we believe that your journal will make an excellent contribution to their knowledge and aid in treatment.

Miss Colette M. Oberembt
Coordinator-Medical Social Work
Marquette University
School of Medicine
Milkaukee, Wisconsin

Shepherd

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If Alcoholics Are Forced Into Treatment, Will It Work?

BY ERNEST A. SHEPHERD

CHIEF, ALCOHOLISM DIVISION
CONNECTICUT STATE DEPARTMENT OF MENTAL HEALTH

COERCION and controls are not limited to legal ones. Many kinds of social controls compel alcoholics to take steps toward sobriety which they do not want.

It may be an angry wife who literally drags her husband to the rehabilitation center and practically pushes the body through the door exclaiming as she does, "*He* wants treatment!"

It may be the final notice of the employer to his employee that he won't have a job any longer unless he can straighten up and fly right. It may be any number of threats or direct actions which intervene in the drinking to coerce the alcoholic reluctantly to examine his problem and look for help.

Dr. E. M. Jellinek, one of the great and famous students of the problems of the alcoholic, pointed out that one of the defenses by which the alcoholic protects his drinking pattern and practices is a wall of excuses and rationalization which he builds around them—the "alibi system."

Dr. Jellinek many years ago observed that, unless and until something or somebody penetrates and cracks this alibi system or wall of excuses and rationalization, the alcoholic is most likely to continue in his drinking ways.

Naturally, the question arises can some type or types of coercion be so used as to break down the alibi system exposing the alcoholic to the realities of his life? If so, what kind of coercion is most effective?

A number of major businesses and corporations have instituted special activities which are designed to locate and assist problem drinkers among their employees, and it is significant to note that those programs do not hesitate to use direct intervention in the problem drinker's behavior. They employ some type of coercion in having him consider treatment for his condition.

Frequently, if a problem drinker is detected, he will be frankly confronted by a supervisor with the description of his behavior and will be suspended from work with orders to report to the medical department for examination and treatment. He may then be referred to some special rehabilitation service with the requirement that if he does not cooperate, his job will end.

One of the outstanding industrial alcoholism programs is the program of the Consolidated Edison Company in New York City. This company frankly forces the problem drinker by threat of loss of job toward definite help.

The results are most gratifying. Of the cases located and treated, 60 per cent were successful. The successfully treated employees returned to their jobs and maintained sobriety for extended periods of time.

This experience of the Consolidated Edison Company can be matched by other large industrial concerns and businesses, and their successes must be related at least in part to the constructive use of control and coercion for rehabilitation.

As these were probably high type employees, the question may well be asked, will this approach work with other kinds of people? After all, there have been many failures in the past when people tried to force alcoholics to take treatment.

The number of problem drinkers who are arrested, jailed, and soon released only to be hauled back to jail on their next bout is staggering. The statistics vary from place to place and may change with changes in the attitudes of the local police, judges, and jail personnel.

One thing is certain: The "revolving door" policy as a single type of coercion does not help the problem drinker or anyone concerned with him. In addition, it constitutes a heavy financial burden on society.

However, there are recent reports from programs in Washington, D. C. and other metropolitan areas where judges, probation services and police have worked together for a sufficient period of time to have results which can be checked and studied. These reports indicate that coercion combined with rehabilitation services can be effective to a degree.

Over twenty years ago, Austin McCormick deplored the existing conditions and the fact that the rapid turnover of alcoholics precluded effective management even in jails with well-trained staff.

Coercion and controls are not limited to legal ones.

In 1945, H. B. Gill of the District of Columbia penal institutions suggested that superintendents, wardens, and other jail staff should acquaint themselves with the Alcoholics Anonymous program and enlist the help of AA members to deal with alcoholics who could not be treated in hospitals or at home.

Seldon D. Bacon, noting that most of the jailed alcoholics could not hope to be treated in open clinics or hospitals, proposed that the jail itself become the center of programs to start the rehabilitation of those problem drinkers who spend much of their lives in prisons. Attempts to organize treatment connected with jails or courts then started nationwide.

The Seattle Police Department began its Rehabilitation Project for Alcoholics in 1947, with a camp organized to accommodate 200 men. There were no voluntary admissions, and the inmates were selected by police personnel from among the jail population of the repeated arrested.

Regular hours, healthful food, and adequate work at the camp constitut-

ed the first phase of the rehabilitative program. Placement of the men in jobs outside the camp was the second phase.

Over the years the project underwent various modifications including the addition to the staff of two members of AA to provide formal counseling for patients who wished it.

Routine work and regular hours, though still emphasized, were supplemented by educational films and discussions, and informal counseling by members of AA on the staff and from outside groups.

Ten years after the start of the project, a group of sociologists headed by Joan K. Jackson, Ph.D., evaluated the results. They concluded that about 70 per cent of a random sample of the men benefited from the program. A particularly significant factor in achieving good results was the amount of formal counseling which the patients received.

In the District of Columbia Workhouse, a 2½ year project was undertaken in 1954 to test the value of a clinic within a prison setting. The workhouse, an open door institution in an isolated country setting, had an average population of 1,300 inmates with a commitment period limited by law to 90 days.

The clinic could take care of 20 patients at a time. Each was assigned for weekly individual therapy sessions to one staff member who might be a psychiatrist, a psychologist, a nurse or a social worker.

The patients also participated in group therapy once or twice a week and occupational and recreational therapy were provided. Work assignments were given within the regular program of the institution.

Before discharge the economic and social needs of each patient were studied and efforts were made to provide the basic needs for food, lodging, clothing, and employment at the time of release.

During the follow-up period, lasting between three months and three years, 23 of the 100 treated inmates could not be traced. Of the remaining 77, 32 definitely improved; 45 did not.

D. F. Mindlin, reporting these results, concluded that although at least one out of three of these jailed alcoholics had improved through enforced psychiatric treatment, they represented a select group and lesser percentages of success could be expected with unselected prisoners treated so briefly.

More recently, in the District of Columbia, the problem is being met through the Municipal Court Alcoholic Rehabilitation Unit. When a man is found guilty of intoxication, a probation officer quickly evaluates his potential. If it appears he might profit from the program, he is returned to jail to sober up and get into a suitable physical condition. Then he is taken back before the court.

The men meet daily, Tuesday through Friday, with two probation officers and three to five AA members. The AA program is explained,

"He wants treatment!"

the court program outlined, and the men are offered a chance to try it. There is no requirement of acceptance at this point. To those who accept it, the only request is that they attend weekly meetings about AA, held in a courtroom. The Alcoholic Rehabilitation Unit is not an AA group, but it employs AA principles and philosophy.

A man who accepts the program then appears in court and the probation officer recommends release on personal bond. This amounts to a suspended sentence. Each man is assisted in arranging temporary food and lodging if necessary, as well as employment and job counseling. The unit office also handles personal problems. Referrals may be made to community agencies for various needs.

Of 32,889 people appearing in court in an 18-month period, 8,303 were screened by the unit and 4,440 were released to it on probation. Of these, 2,438 did not reappear in court for at least 6 months, the period taken as a "measuring stick of success."

A unique set-up at the Massachusetts Correctional Institution in Framingham is described by D. Myerson. A 1955 law makes it mandatory to refer alcoholics from state prisons to a medical clinic for follow-up.

A pilot project, designed to carry out the intent of this legislation, provided continuous "relationship therapy" for women alcoholics at the Framingham Institution during their confinement and on their transfer to the alcoholism clinic after release.

Two psychiatric social workers from the Peter Bent Brigham Hospital would spend one afternoon a week at the correctional institution seeing and consulting with several women each time. Between 10 and 45 minutes would be devoted to each woman, depending on her response to the visit.

The same therapist continued with each woman after her release, when the treatment was generally supportive, and usually centered about the patient's reactions to separation from the prison and readjustment in the larger community.

Of the women seen thus while in prison, 20 quit treatment after their release. Eighteen continued the therapeutic relationship and are considered as definitely successful cases in that the women used either the therapeutic relationship or the hospital facilities to their advantage. Seven others who continued the interviews could not stop their uncontrolled drinking and were re-arrested. The remaining four women visited the clinic sporadically but without any demonstrable advantage.

Myerson concluded that sustained therapeutic relationships do contribute to successful transfer from prison to clinic treatment.

Undoubtedly, many prisoners have been helped. But all who have evaluated and reported on the projects admit insufficient progress.

The results of those various efforts are better than many have expected, even though many are partial. Similar work is underway at Portland, Oregon; Columbus, Ohio; Chicago, Illinois; New Haven, Connecticut; Worcester, Massachusetts; Detroit, Michigan; and Toronto, Canada.

In all of these projects, varying amounts and kinds of coercion are effectively geared to the use of rehabilitation services and the statistical returns bear careful scrutiny as hopeful ones.

These reports are strong indications that coercion and control of various kinds may be so applied to the management of alcoholics that they assist rehabilitation rather than militate against it.

The following article, an abridged version of a paper presented at the National Conference on Social Welfare which met in Los Angeles, California May 26, 1964, is reprinted from the *News* by permission of the authors. Herman E. Krimmel and Helen R. Spears are director and casework supervisor, respectively, of the Cleveland Center on Alcoholism.

When the social and psychological situation of the family is already grim, the addition of alcoholism makes it tragically dramatic.

The Effect of Parental Alcoholism on Adolescents

BY HERMAN E. KRIMMEL and HELEN R. SPEARS

On a mild summer evening a Mr. Shaw took his son, George Bernard, for a walk along Dublin's Grand Canal. The elder Shaw, feeling jocular from the effects of good whisky, threatened to throw his son into the water and, in a clumsy pretense, very nearly did. The boy had never really been aware of his father's tippling habits but this incident opened his eyes. "Mama," he cried on his return home, "I think papa is drunk!" Bitterly, Mrs. Shaw replied: "When is he ever anything else?"

In recounting this episode, one of Shaw's biographers, St. John Ervine, observed that "the disillusionment of a child is a bitter experience and is never forgotten." Years later, when sentimentalists accused Shaw of disrespect for his father's memory, the playwright angrily recalled the anguish that had been created in the home and how, as Ervine says, Mr. Shaw's chronic intoxication made Dublin a desert for the family.

There was violence in the Shaw home. Although the father was an amiable enough man when sober, his temper was fearsome when drunk. The slightest offense was enough to make him smash anything breakable that might be lying about. Frequently, the three children "huddled apprehensively in the kitchen, hoping that their father would be sober when he came home from his mill."

His behavior cut the family off from the social life of the numerous Shaw clan and they suffered the stigma of being outcasts. Because he was unwelcome, his wife and children felt excluded, too.

This pattern is familiar in the families of alcoholics; it has been repeated countless thousands of times.

The memory of his father's alcoholism was long and deep for Shaw. It left scars and made him a fanatical teetotaler. This dedicated abstinence may not have been an ideal defense but it served Shaw well enough and was socially innocuous. But if fanaticism, even in an isolated area, can be the result in a George Bernard Shaw, what happens to lesser persons?

It has been generally agreed that parental alcoholism is detrimental to children. There have been few studies in this field but in those that have been made the results have been similar. In her book, **Wednesday's Children,** Leontine Young recently reported a study of abused and neglected children which revealed that alcoholism was one of the most acute problems. In 300 families, 186 parents were severe and chronic drinkers and their drinking constituted a primary family problem.

Other studies have consistently reported a significantly high incidence of anxiety neurosis, depression, hostility and sexual confusion among the children of alcoholics.

The sample in the study recently completed at the Cleveland Center on Alcoholism included 125 adolescents of both sexes about evenly divided. They ranged in age from thirteen to twenty-one and the average age was seventeen. They included children of clinic patients, members of Alateen groups, those on probation in juvenile courts, clients of private agencies and delinquent children in state institutions.

In a number of areas there seemed to be no significant differences among alcoholic and non-alcoholic families. Disciplinary measures, such as curfews, were similar as was the latitude permitted to children in selecting friends. The demands on the children to earn money and possible restrictions on their use of it could not be clearly differentiated by groups.

However, there were areas in which the impact of parental alcoholism seemed clear. Certain difficulties appeared almost universally in alcoholic families and were relatively uncommon in non-alcoholic families no matter how torn by other disorders the latter might be. In alcoholic families there were structural changes that left children confused and without identification. There was widespread violence. The ability of children to form healthy relationships was severely crippled. Goals were abandoned and there was a retreat to defenses that were sometimes as unworkable as they were unhealthy.

Affected All Groups

One factor should be emphasized, however. The impact of alcoholism affected all groups without regard to social, cultural, racial or economic situations.

The change in family structure occurred almost without exception in the alcoholic families and the adolescents were resentful of the sense they had of being "different." They didn't always say it that directly but they were obviously uneasy in the knowledge that their parents were not like other parents; their families were not like other families.

In our society it is customary to regard the father as head of the household and, for better or worse, children want it that way. However, few of those in our sample saw their fathers in that role. A typical remark was that of a seventeen-year-old boy who said his father was either away from home working or drinking or at home sleeping off a hangover.

It is difficult, frequently impossible, for the child of an alcoholic to establish

the necessary identification with an alcoholic parent when the latter no longer behaves as a parent and is relegated to the position of another child. This has been verified in many interviews with adolescents and confirmed by wives who say they do not have husbands but only additional children to care for. Among adolescents who need identification, this can be a source of severe conflict.

If a parent were just relegated to an inappropriate position, the situation would be bad enough, but the fact remains that he cannot be ignored. He may use his drinking to insure his position as the center of attention. The focus frequently remains on the drinking of the alcoholic member because family plans, even family economics, may depend on his intoxication or sobriety. Long range planning is almost impossible because of this unpredictability.

Deterioration within the family is accompanied by guilt which may spread like a virus to spouses and children. They are compelled to witness or participate in situations that make them feel, however unjustly, guilt by association.

With guilt comes isolation. One mother withdrew from all outside groups because she was apprehensive about her husband's treatment of the children while she was absent. She stopped going to a monthly bridge club and withdrew from the church choir after she returned from one rehearsal and found her alcoholic husband in bed with their thirteen-year-old daughter. Somehow, she blamed herself as well as her husband.

Decades have passed since the Shaw family was forced into isolation but intolerant community attitudes continue to force family withdrawal. An adolescent who repeatedly had to haul his father from the tavern, take him home and put him to bed told of the anger and nausea that nearly overwhelmed him each time it happened. He was afraid to face his friends after each episode and equally afraid to abandon his father.

It is scant comfort for a child to be told that the professional party line is that alcoholism is an illness rather than a sin or evidence of moral turpitude. He is far more sensitive to the whips and scorns of classmates and neighbors than to the reassurance of social workers and psychiatrists.

Isolation and loss of external contacts compel concentration on the behavior of other members of the family. This can only emphasize changes in family structure. Moreover, in many cases, it exposes the child to exploitation by both parents. Most of the children in the study were used as weapons in the war between the alcoholic and non-alcoholic parents although they were not always aware of the exploitation. Many of the adolescents felt a disturbing sense of inner conflict and knew that, somehow, it was related to drinking but could not identify the cause.

Increases Conflicts

Almost all the adolescents emphasized the demands made on them to take sides. This happens in other families, too, but where alcoholism is involved the lines are more likely to be drawn between the "good" and the "bad" which can increase rather than alleviate conflicts.

Mothers were most successful in commanding loyalty and there was almost unanimous determination among the boys to protect the mothers whether they were alcoholic or non-alcoholic. The girls were more divided although they, too, tended to protect the mother. One girl frequently feigned illness to stay home from school when she thought there might be trouble because she felt she should be where she could intercede.

It was our observation that the need felt by children to act as protectors decreased as they grew older. Their fears diminished as they became accustomed to the situation and they seemed to adopt a studied aloofness to parental conflicts.

(Continued on page 14)

THE STORK DELIVERS AGAIN: The stork delivered its third baby girl of 1964 to female staff members of the Education Division with the arrival of Jennifer Lynn Ransdell on October 28. The proud parents—Jackie Ransdell, assistant editor of **Inventory,** and her husband, Ernie—and baby daughter are doing fine. Considering the fact that there were only three married female staff members at the beginning of the year, we take great pride in this 100 per cent record. The other deliveries were Beverly Inez Pike, daughter of Lillian Pike, editor of **Inventory,** and her husband, Jim; and Jacqueline Lucille Bailey, daughter of Ruby Bailey, office secretary, and her husband, Kenneth. All three were preceded in July of 1963 by Sharon Eldridge Adams, daughter of communications consultant, George Adams, and his wife, Nancy.

WASHINGTON, D. C.: The North American Association of Alcoholism Programs is now open to individuals having a professional interest in the problems of alcohol and alcoholism. The Association, formerly comprised only of tax supported agencies in the field of alcoholism, now has an individual membership category with an annual fee of $7.50. For more information, write to: North American Association of Alcoholism Programs, 323 Dupont Circle Building, Washington, D. C.

RALEIGH, N. C.: North Carolina has recently added several new local alcoholism programs to its growing list. Information centers have been opened in Wadesboro, Yadkinville and Greenville. This brings to 20 the number of such programs in North Carolina.

A.A. MEMBERS: Based on figures reported to the General Service Office of Alcoholics Anonymous recently, the number of A. A. members throughout the world totals 209,434. Including "non-reported" members, actual membership is estimated at more than 350,000. This includes 122,483 members in the United States, 15,410 in Canada and 32,071 overseas. Members in hospitals and prisons and loners and internationalists make up the remainder of the total.

SANFORD, N. C.: Some fifteen officers of the North Carolina Prison Department participated in a week-long alcohol education training program at the Prison Training Center in Sanford October 19-23. The program was a follow-up course for those who attended the Summer School of Alcohol Studies at the University of North Carolina last June. These officers are currently conducting an alcohol education program in their respective prison units on a pilot basis. The institute was sponsored by the Alcoholism Programs of North Carolina, the Alcoholic Rehabilitation Division of the N. C. Prison Department and the Education Division, N. C. Department of Mental Health.

GREENSBORO, N. C.: The Greensboro Council on Alcoholism served as host for the semi-annual meeting of the Alcoholism Programs of North Carolina on November 6.

RALEIGH, N. C.: A series of programs on alcoholism for social workers, law enforcement officers and public health nurses in Wake County was held at Enloe High School in Raleigh November 9, 16 and 23. Joining together to sponsor the sessions were the Wake County Health Department, the N. C. Department of Mental Health and the Wake County Mental Health Association.

BUTNER, N. C.: The month of October saw the number of first admissions to the Alcoholic Rehabilitation Center at Butner reach 5,000. It is estimated that in the 14 years of the Center's existence approximately 7,500 patients have been admitted to the Center, including re-admissions.

BURLINGTON, N. C.: The Alamance County Council on Alcoholism, headed by executive director Margaret Brothers, held its annual meeting on November 12 in Burlington. Guest speaker for the occasion was Dr. Norman A. Desrosiers, medical director of the Alcoholic Rehabilitation Center at Butner.

CHARLESTON, WEST VIRGINIA: Former executive director of the Asheville alcoholism program, Donald Dancy, who resigned to accept the position of supervisor of the newly established alcoholism division of the West Virginia Department of Mental Health, reports that the first year of the program's operation has been a productive one. The main accomplishment has been the establishment of a workable philosophy and approach for program development in the area of alcoholism. Increased interest and financial support from both the state and federal governments, improved services for the alcoholic in the alcoholic treatment programs and training programs for departmental personnel are some of the reasons the coming months should be both busy and challenging ones.

RALEIGH, N. C.: The N. C. Department of Mental Health sponsored two exhibits at the North Carolina State Fair in October. The themes for the displays were "A Plan For the Control of Alcoholism and Rehabilitation of the Alcoholic" and "Goals For Mental Health."

NEW YORK, N. Y.: The National Council on Alcoholism has announced that National Alcoholism Information Week will be held November 29-December 5 this year. The Education Division, N. C. Department of Mental Health will join in this observance together with the state's twenty local alcoholism programs.

RALEIGH, N. C.: George Adams, communications consultant with the Education Division, N. C. Department of Mental Health, served as a lecturer on alcoholism in the Police Institute for new police officers in Raleigh on October 30.

CORRECTION

The September-October, 1964 issue of **Inventory** carried an article entitled "The Lonely Road" by C. Robert Dickey. It was erroneously reported that the author was Information Officer at the Alcoholism Foundation of Alberta. Actually, Mr. Dickey is executive director of the Canadian Mental Health Association and has been for some time. This was discovered too late, as **Inventory** had already gone to press. The editors apologize to Mr. Dickey for this error and wish to take this opportunity to correct their mistake.

CONTINUED FROM PAGE 11

Moreover, many could afford to resist involvement as they realized they were not responsible for parental difficulties. This had been a source of desperate anxieties for many when they were younger.

The reorganization of the family frequently compels children to prematurely assume adult responsibilities. One fifteen-year-old boy whose father's alcoholism erupted when the child was only nine, was told by his mother at that time that he would have to be "man of the house." That is reminiscent of the lament of the alcoholic father in **Days of Wine and Roses** when he cries out to his wife: "We get drunk. We stay drunk. Poor little Debbie. It's like we're her children instead of the other way around . . ."

We know that adolescents sometimes succeed with these responsibilities, but that is not synonymous with suggesting that the burdens are healthy.

Regardless of the degree of distortion of structure, violence was almost universal in families with alcoholism and infrequent in others, although the latter were often riddled with different kinds of pathology.

Generally, it seemed that the alcoholics drank, in part at least, to overcome a sense of inadequacy. Consequently, passive fathers exploded into uncontrollable rages under the influence of alcohol. Many of our subjects had been witnesses to, or victims of, such outbursts since early childhood.

Violence, of course, is not the monopoly of male parents. In one family, both parents had been drinking for eight years at the time we saw the two teen-age children. The mother became so violent that she stopped at nothing to harm those who were "against her." The injuries she inflicted on her husband included broken fingers, cracked ribs, teeth knocked out, a broken nose and innumerable stab wounds from knives, forks and other weapons.

Both children said the father was also a severe alcoholic although rather passive when drunk. Indeed, one of their complaints was his inability to do anything about the situation or even to resist his wife's fury.

The scars of violence can last a lifetime. Actress Ethel Waters was raised in a home that included two aunts whose drunkenness was unbearable. Miss Waters recalls that their inebriation and the violence and quarreling it brought out was something she could never accept. On an unforgettable Christmas Eve, one of the aunts came home riotously intoxicated. Ethel vigorously objected. The aunt cursed her and threw a hatchet. The hatchet, fortunately, missed its physical target but the act itself made emotional cuts that were deep and lasting.

Impact of Violence

One factor that impressed us was the direct relationship between the impact of violence and the age at which children first witnessed the episodes. The younger they were, the more devastating and lasting was the effect. After the first incident, they were always waiting for the next and the next after that. They learned to equate drinking with violence almost as a conditioned response.

Another finding of the study was that these multiple manifestations of conflict, turmoil and distortion seriously impaired the ability of children to form healthy relationships in or out of the family.

Few of the adolescents in the sample had developed that ability and it seemed that they never really had a chance. Most alcoholic families are models only of inconsistency and instability. The periods of sobriety may offer interludes of peace and warmth and even a measure of happiness to the non-alcoholic members of the family, but they are only interludes. For children there may scarcely be time to readjust their thinking before the alcoholic parent is off and running again.

Most of the boys and girls expressed disappointment and resentment at being let down over and over again by the alcoholic parent.

A seventeen-year-old boy, seen at a private agency because of truancy and school failure, finally revealed his brooding resentment about the numerous parental separations that resulted from his father's excessive drinking. For him, however, it wasn't any better when they were together because conflict erupted every time the father got drunk. When the father was not drinking, he was passive, ineffectual and removed from the mainstream of the daily functioning of the family.

This boy had never known an example of mature love and the constancy of a healthy parental relationship. He never knew what to expect so he withdrew. He was afraid to test relationships because he had been bruised by adults and was uneasy with his peers. Although he was an attractive young man, he was inhibited with girls and expressed doubt that he could ever achieve an easy, comfortable relationship with them.

Another boy became dejected and hopeless about his situation at home and while he refused to leave physically, he withdrew emotionally. The school described him as an "isolate" although quite dependable and hard-working. He had no friends because he was suspicious of the motives of people and could not accept anyone who was not "perfect in every way."

The insecurity which is a barrier to relationships is often increased in alcoholic families by the almost inevitable war between the parents which compels them to devote most of themselves to warfare instead of to total family living. There is seldom genuine peace—just truces. Children, being resilient organisms, may strive again and again for healthy relationships but just as achievement seems close, it is blocked by another binge of an alcoholic parent.

How many times can they try? How many times can they accept frustration without giving up? The position of the child of an alcoholic marriage is like that of a ballplayer on the bench who is never called into the game and cannot, therefore, develop his skills. The ability to develop healthy relationships comes only from practice.

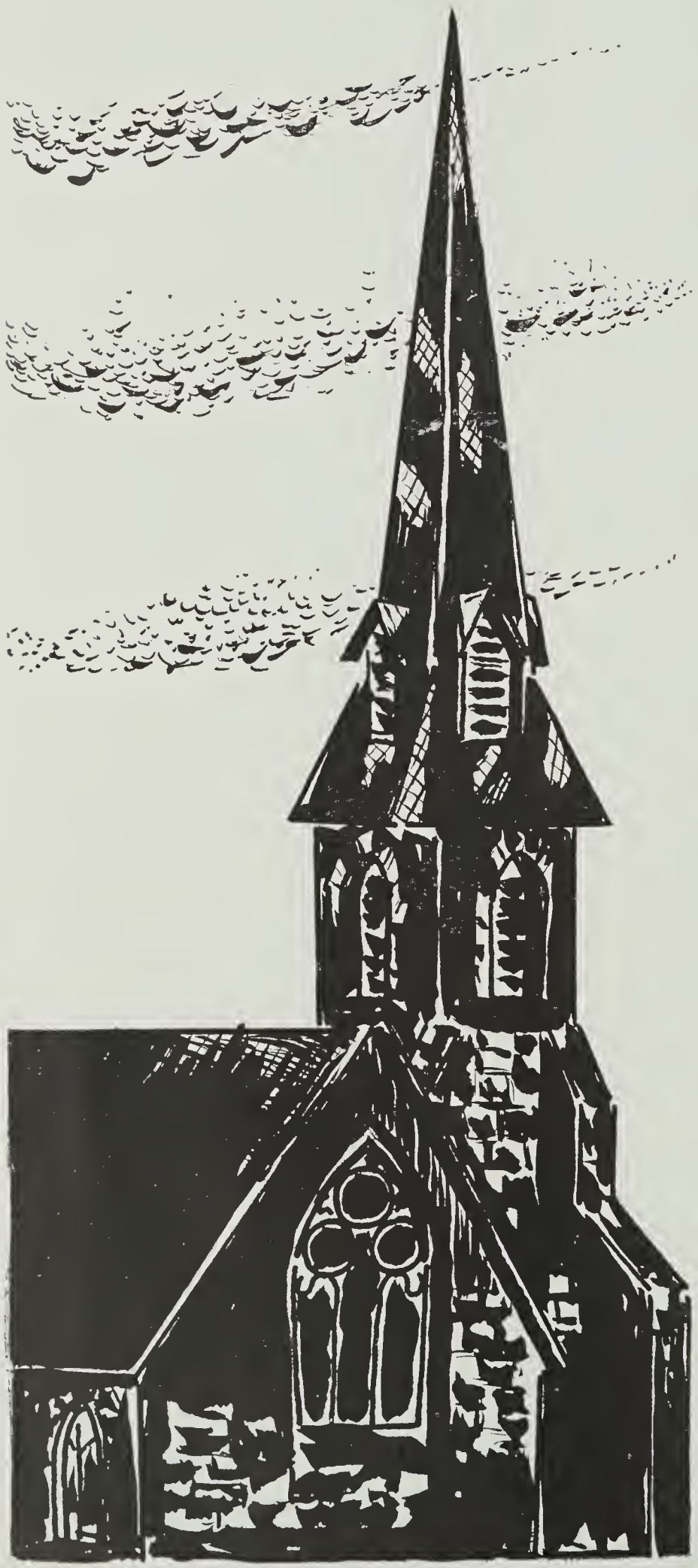
Children stunted in their relationships seem to be also limited in a sense of their own worth. Among the adolescents in the study there were severe limitations and distortions of self-image because confidence and self-assurance find little nourishment in an atmosphere of doubt and recriminations.

Many of the alcoholic parents were perfectionists—for everyone except themselves. They made impossible demands on children in behavior and accomplishments to compensate for their own failures. The children, unable to meet these demands, developed a sense of impotence and worthlessness.

State of Anomie

For many young girls and boys in our study, all these factors added up to a state of anomie. Many aspired to higher standards than those of their parents, to a life undamaged by, if not necessarily free of, alcohol. But aspirations were vague and undefined which may not be an uncommon phenomenon among adolescents, but among these children, everything was subordinated to the immediate goal of finding a way to live with an alcoholic parent or to escape.

Some authorities have indicated that it is not possible to say with assurance that alcoholism is **the** factor primarily responsible for the difficulties we have indicated. This may be true. However, the insistent regularity of the factors in alcoholic families must indicate that the risks are great and when the social and psychological situation of the family is already grim, the addition of alcoholism makes it tragically dramatic.



WHAT the CHURCH HAS to LEARN from Alcoholics Anonymous

BY
THE LATE REVEREND
SAMUEL M. SHOEMAKER, D.D.

NEARLY everyone knows of the remarkable movement called Alcoholics Anonymous. It happens that I have watched the unfolding of this movement with more than usual interest, for its real founder and guiding spirit, Bill W., found his initial spiritual answer at Calvary Church in New York when I was rector there in 1935. Having met two men, unmistakable alcoholics, who had found release from their difficulty, he was moved to seek out the same answer for himself. But he went further. Being of a foraging and inquiring mind, he began to think there was some general law operating here which could be made to work, not in two men's lives only but in two thousand or two million. He set to work to find out what it was and, in the process, consulted psychiatrists, doctors, clergymen and recovered alcoholics.

The first actual group was not in New York, but in Akron, Ohio. Bill was spending a weekend there in a hotel. The crowd was moving towards the bar. He was lonely and felt danger assailing him. He consulted the church directory in the hotel lobby, and found the name of a local clergyman and his church. He called the clergyman on the telephone and said, "I am an alcoholic down here at the hotel. The going is a little hard just now. Have you anybody you think I might meet and talk to?" He was given the name of a woman who belonged to one of the great tire manufacturing families. Bill called her; she invited him out at once and said she had a man she wanted him to meet. While he was on his way, she called Dr. Bob S. and his wife, Anne. Dr. Bob told her he'd give her five minutes. He stayed five hours and told Bill, "You're the only man I've ever seen with the answer to alcoholism." And there was begun, nearly thirty years ago, the first Alcoholics Anonymous group.

The number of groups now is beyond count. Some say there are around 300,000 recovered alcoholics, but nobody knows how many extend beyond this into the fringes of the unknown. Professor Austin McCormick of Berkeley, California, former Commissioner of Correction in the city of New York, once said that A. A. may "prove to be one of the greatest movements of all time." That was years ago. Subsequent facts support his prophecy.

At a National Convention of A. A. some time ago, I was asked to talk, together with Father Edward Dowling, a wonderful Roman Catholic priest who has performed notable service for A. A. in interpreting it to his people, and Dr. Jim S., a most remarkable colored physician of Washington, on the spiritual aspects of the A. A. program. They were very generous to non-alcoholics, but I should have preferred that only a bona fide alcoholic did the speaking.

In the course of what I said to them, I remarked that I thought it

". . . God chose what is foolish in the world to shame the wise, God chose what is weak in the world to shame the strong . . ."

I Corinthians 1: 26

"What the Church Has to Learn from Alcoholics Anonymous" was broadcast February 16, 1958 on *The Episcopal Hour* and later published in pamphlet form by the Texas Commission on Alcoholism. The age of A. A. and the estimated number of recovered alcoholics in A.A. has been changed to a more current figure. Otherwise, it is as he gave it.

had been wise of A. A. to confine its activity to alcoholics. But, I added, "I think we may see an effect of A. A. on medicine, on psychiatry, on correction, on the ever-present problem of human nature; and not least, on the Church. Now perhaps the time has come for the Church to be reawakened and revitalized by those insights and practices found in A. A."

I think some of you may be a little surprised at this suggestion. I fear you will be saying to yourself, "What have we, who have always been decent people, to learn from a lot of reconstructed drunks?" And perhaps you may, thereby, reveal to yourself how very far you are from the spirit of Christ and the Gospel, and how very much in need of precisely the kind of checkup that may come to us from A. A. If I need a text for what I say to you, there is one in I Corinthians 1:26, ". . . God chose what is foolish in the world to shame the wise, God chose what is weak in the world to shame the strong." I need not remind you that there is a good deal of sarcasm in that verse; because it must be evident that anything God can use is neither foolish nor weak, and that if we consider ourselves wise and strong, we may need to go to school under some whom we have called foolish and weak.

The first thing I think the Church needs to learn from A. A. is that *nobody gets anywhere until he recognizes a clearly defined need.* These people do not come to A. A. to get made a *little* better. They come because they are desperate. They are not ladies and gentlemen looking for a religion; they are utterly desperate men and women in search of redemption. Without what A. A. gives, death stares them in the face. With what A. A. gives them, there is life and hope. There are not a dozen ways, there are not two ways, there is one way for them; and they find it, or perish. A. A.'s, each and all, have a definite, desperate need. They have the need, and they are ready to tell somebody what it is if they see the least chance that it can be met.

Is there anything as definite for you or me, who may happen not to be alcoholics? If there is, I am sure that it lies in the realm of our conscious withholding of the truth about ourselves from God and from one another, by pretending that we are already good Christians. Let me quote here from a most amazing book, *Report to the Creator,* by Jerome Ellison, a member of A. A.: He says, "The relief of being accepted can never be known by one who has never thought himself unacceptable. I hear of 'good Christian men and women' belonging to 'fine old church families.' There were no Christians in the first church, only sinners. Peter never let himself or his hearers forget his betrayal in the hour the cock crew. James, stung by the memory of his years of stubborn resistance, warned the church members: 'Confess your faults to one another.' That was before there were 'fine old church families.' Today the last place where one can be candid about one's faults is in church. In a bar, yes, in a church, no. I know; I've tried both places." Let that sting you and me just as it should, and make us miserable with our church Phariseeism, until we see it just as definite and

? reawakened and ractices found in A. A.

just as hideous as anybody's drunkenness can ever be, and a great deal more really dangerous.

The second thing the Church needs to learn from A. A. is that *men are redeemed in a life-changing fellowship.* A. A. does not expect to let anybody who comes in stay as he is. They know he is in need and must have help. They live for nothing else but to extend and keep extending that help. Like the Church, they did not begin in glorious Gothic structures, but in houses or caves in the earth—wherever they could get a foothold, meet people, and gather. It never occurs to an A. A. that it is enough for him to sit down and polish his spiritual nails all by himself, or dust off his soul all by himself, or spend a couple of minutes praying each day all by himself. His soul gets kept in order by trying to help other people get their souls in order, with the help of God. At once a new person takes his place in this redeeming, life-changing fellowship. He may be changed today, and out working tomorrow—no long, senseless delays about giving away what he has. He's ready to give the little he has the moment it comes to him. The fellowship that redeemed him will wither and die unless he and others like him get in and keep that fellowship moving and growing by reaching others.

"A life-changing fellowship" sounds like a description of the church. It is, of the *ideal* Church. But how many churches are actually ideal? The laymen say this is the minister's job, and the ministers say it is the evangelist's job, and everybody finds a rationalized excuse for not doing what every Christian ought to be doing, i. e., bringing other people into the redeeming, life-changing fellowship.

The third thing the Church needs to learn from A. A. is *the necessity for definite personal dealing with people.* A. A.'s know all the stock excuses—they've used them themselves and heard them a hundred times: All the blame is put on someone else—"My temperament is different, I've tried it and it doesn't work for me. I'm not really so bad, I just slip a little sometimes." They've heard them all, and know them for the rationalized pack of lies they are. They constitute, taken together, the Gospel of Hell and Failure. I've heard A. A.'s laboring with one another, now patient as a mother, now savage as a prizefighter, now careful in explanation, now pounding in a heavy personal challenge, but always knowing the desperate need and the sure answer.

Are we in the Church like that? Have you ever been drastically dealt with by anybody? Have you ever dared to be drastic in love with anybody? We are so official, so polite, so ready to accept ourselves and each other at face value. I went for years before ever I met a man that dared talk about my real needs, create a situation in which I could be honest with him, and hold me to a specific Christian commitment and decision. One can find kindness and even good advice in the Church. That is not all men need. They need to be helped to face themselves as they really are. I think many of us in the Church see ourselves as we should like to appear to others, not as we are before God. We need drastic personal dealing and challenge. Who is ready and trained to give it to us? How many of us have ever taken a "fearless moral inventory" of ourselves, and dared

make the depth of our need known to any other human being? This gets at the pride which is the hindrance and sticking-point for so many of us, and which, for most of us in the Church, has never even been recognized, let alone faced or dealt with.

The fourth thing the Church needs to learn from A. A. is *the necessity for a real change of heart, a true conversion.* As we come Sunday after Sunday, year after year, we are supposed to be in a process of transformation. Are we? The A. A.'s seem to be. At each meeting there are people who are seeking and in conscious need. Everybody is pulling for the people who speak, and looking for more insight and help. They are pulled by the inspiration of others who are growing. They are a society of the "before and after," with a clear line between the old life and the new. This is not the difference between sinfulness and perfection, but it is the difference between accepted wrong-doing and the genuine beginning of a new way of life.

How about us? Again, I quote Jerome Ellison in his report to God: ". . . I began to see that many of the parishioners did not really want to find You, because finding You would change them from their habitual ways, and they did not want to endure the pain of change . . . For our churchmanlike crimes of bland, impenetrable pose, I offer shame . . ." I suppose that the sheer visibility of the alcoholic problem creates a kind of enforced honesty; but surely if we are exposed again and again to God, to Christ, to the Cross, there should be a breaking down of our pride and unwillingness to change. We should know by now that this unwillingness, multiplied by thousands and tens of thousands, is what is the matter with the Church, and what keeps it from being what God means it to be on earth. The change must begin somewhere. We know it ought to begin in us.

One of the greatest things the Church should learn from A. A. is *the need people have for an exposure to living Christian experience.* In thousands of places, alcoholics (and others) can go and hear recovered alcoholics speak about their experiences, and watch the process of new life and outlook take place before their eyes. The A. A.'s say that their public relations are based, not on promotion, but on attraction. This attraction begins when you see people with problems like your own, hear them speaking freely of the answers they are finding, and realize that such honesty and such change are exactly what you need yourself.

No ordinary service of worship in the Church can possibly do this. We need to supplement what we do now by the establishment of informal companies where people who are spiritually seeking can see how faith takes hold in other lives, how the characteristically Christian experience comes to them. Some churches are doing this, but not nearly enough of them. There is one that I know where on Sunday evenings laymen and women speak simply about what has happened to them spiritually; it is drawing many more by attraction. This needs to be multiplied by the tens of thousands, and the Church itself awakened.

As I looked out over the crowd of five thousand alcoholics at that convention, I said to myself, "Would that the Church were like this—ordinary men and women with great need who have found a great Answer, and do not hesitate to make it known wherever they can—a trained army of enthusiastic, humble, human workers whose efforts make life a different thing for other people!"

Research on Alcoholism and the Family

BY JOAN K. JACKSON, Ph.D.

Research on alcoholism and the family is helping to bring about long overdue change in attitude toward members of the alcoholic's family.

THE research at the University of Washington in Seattle on alcoholism and the family has been a very exciting experience for all of us. Not only did we get a chance to establish ties with Seattle Al-Anon's New Zealand sisters, but we also had the opportunity of coming to know well over 100 of the valiant American women who are managing to keep their families' welfare paramount in the face of the difficult and serious illness of alcoholism. A second exciting aspect has been the growth of interest and research on alcoholism and the family in this country, partly as an outgrowth of our own research.

That Al-Anon members, who are gathered together to help themselves, have contributed so much to the greater understanding of all families of alcoholics should be a great source of pride. Families who have not benefited through direct Al-Anon experience are receiving indirect benefits. Due to the willingness of Al-Anon members to share their experiences with researchers who then transmit them to professionals in books and journals, other families of alcoholics are receiving more realistic services from counselors, doctors, clergy and the courts, and greater sympathy from the general public. The professionals, having come to realize what Al-Anon has to offer, are referring their clients to these groups more often and are increasingly interested in receiving more information from them. At least, this is the American experience.

A change in attitude about families of alcoholics and wives of alcoholics was long overdue. The general picture held ten years ago runs something like this: Families of alcoholics are completely disorganized. Children growing up in the home of an alcoholic are almost bound to be psychologically disturbed and socially maladjusted. Wives of alcoholics are crazy or they wouldn't remain with an alcoholic. On the latter point, the professionals put it in more sophisticated language, i.e., the wives of alcoholics share a common and disturbed pattern of personality such that for their own stability they must be married to an alcoholic. Should their alcoholic recover despite them, they would become very emotionally disturbed themselves.

Fortunately, today there is more awareness that much of this point of view belongs with other myths about alcoholism. Just as some alcoholics are skid roaders, so do some families and wives fit this picture. Just as we have learned that the majority of alcoholics are not skid roaders, so have we been able to show that only a minority of the wives and families of alcoholics are this disturbed.

Our research during the past year has given very clear evidence that, although more children of alcoholics than of non-alcoholics are disturbed psychologically,

This article originally appeared in the March, 1963 issue of the New Zealand *Al-Anon Family Groups Magazine* and is reprinted with permission of the author. It is based upon a research study conducted by Dr. Jackson, research associate professor of psychiatry (sociologist), and Kate L. Kogan, Ph.D., clinical associate professor of psychiatry (psychologist), at the University of Washington School of Medicine, Seattle, Washington.

physically and socially, still the majority do not show evidence of being particularly abnormal in any of these areas. To state it another way, if we study 100 children with an alcoholic parent and 100 children with a non-alcoholic parent, we find, that 15 of the children of non-alcoholics are disturbed as compared with 40 from homes which contain an alcoholic. This is obviously more disturbance. It is also clear that 60 per cent of the children of alcoholics are well within the normal range, and this is the majority.

Further, the situation is just not so clearcut as it appears on the surface. On further anlaysis, it becomes evident that alcoholism, per se, is not the villain. Children become disturbed when mothers and fathers, for any reason, default on their jobs as parents and spouses; when children do not understand the reasons behind a parent's unpredictable behavior; when parents use them in their battles with each other. In homes of alcoholics where the children have had alcoholism explained clearly as an illness, in which the alcoholic and his wife are fond of and interested in their children and concerned with their development, and in which the mother maintains a consistent and organized family life, the chances are the child will grow up with fewer problems.

Our findings on the personalities of wives are similar. More wives of alcoholics than of non-alcoholics are emotionally disturbed. This is not surprising to you I am sure. Yet, again the amazing thing is that over half of them appear to manage to live with an alcoholic without becoming disturbed in an abnormal way. Whether or not the wife of an alcoholic is disturbed in a pathological manner depends partly on whether she was already psychologically disturbed when she married and partly on conditions in her marriage. For example, if her husband is physically abusive, she is more likely to become abnormally disturbed than if he is not. Similarly, the greater over-all hardship her family experiences, the more likely she is to be disturbed.

We have no evidence to support the notion that although wives of alcoholics say they want their husbands to become sober, they really don't and would show psychological illness if this happened. Only two of the wives whose husbands have been sober for more than a year have had "nervous breakdowns" and there have been that number of breakdowns in the control group of women not married to alcoholics.

If the wife's personality would fall apart unless she had an alcoholic partner, you would expect that women who didn't have this need would quickly divorce alcoholic partners. While we did find that fewer of those who divorced their husbands were mentally disturbed than those who never made any attempt to divorce, still they were not any different from those who started divorce proceedings but did not go through with them. In addition, those who divorced had lived with the alcoholism problem longer and had made more efforts to help the alcoholic. There was evidence, too, that the decision to divorce or to remain depended on many factors in the current life situation. Women whose husbands were unreliable supporters of the family, who themselves had good job skills, whose husbands were violent to members of the family and constantly in police difficulties were more likely to divorce than those in whose families these conditions did not pertain. Thus, the realtionship between the wife's personality and her husband's alcoholism is far from being a simple relationship, but is complex.

The research has also been able to demonstrate what most Al-Anon members already know, that families of alcoholics are not necessarily more disorganized than families of non-alcoholics. We have been able to show that many alcoholics are good parents despite their drinking, that many support their families well, that many are kind and considerate hus-

bands. The myth that the families of alcoholics are, by definition, disorganized families will fall hard and probably only when study after study is published which cites statistics upon statistics.

The last point from our research which I would like to discuss is the effect of Al-Anon participation on the American families we studied. We have gathered evidence to indicate that regularly attending Al-Anon families reorganize faster and more effectively than those who have attended only a few times, that they become more socially active in the community as shame drops away. The acceptance of the husband's alcoholism and of the futility of trying to change a man who can only change himself, on the surface of it looks like an acceptance of hopelessness. Yet, just as when the alcoholic admits powerlessness only then can hope for recovery be born, so acceptance by the wife of the full implications of the illness leads to emotional relief, and to a rebirth in which she is able to use judgment and wisdom in her interactions with her family, to their benefit and to hers and sometimes to the benefit of the alcoholic also.

Earlier I said research on alcoholism and the family is growing in this country. The National Council on Alcoholism's Margaret Bailey has undertaken a very large and very fine study in New York, including not only Al-Anon members, but also wives of alcoholics who go to social agencies, clergymen and the courts. Other large studies are underway in California and Pennsylvania, again including wives of alcoholics other than Al-Anon members. In addition, there are many smaller studies and thesis projects at many American universities. The portent is for a broadened understanding of the alcoholic's family and ways of helping more effectively.

The popular magazines and press of this country are also transmitting the new information to the general public. Hardly a month goes by without feature articles in at least one local paper and one large women's magazine.

This mounting publicity, which almost always includes references to Al-Anon, has brought new members and new groups. It has also made new demands on Al-Anon members. Al-Anon groups are asked more and more to provide speakers for meetings, for workshops, and for professional courses on alcoholism. It has placed demands on Al-Anon groups to open their meetings, not only to family members of alcoholics, but also to those professionals who would learn more about Al-Anon as a kind of therapy and about the experiences of Al-Anon members as members of the alcoholic's family. It has placed demands on Al-Anon groups, not only to help the family of alcoholics, but also to work together intelligently and sympathetically with those professionals who are at the same time helping some of their members.

Thus, in Seattle today, Al-Anon members are finding new and often difficult roles in the community. At a time when their main need is to help themselves, we are demanding from them almost superhuman objectivity about their life situations, the ability to formulate their experiences in a manner meaningful to those who have never experienced anything like alcoholism, the willingness to reveal themselves and their feelings publicly, and the flexibility and intelligence to work with outsiders as well as insiders. The successfulness of Al-Anon members in such roles has done more to dispel the myths about alcoholism than research and publicity could do in less than a quarter of a century. Like Alcoholics Anonymous, Al-Anon is doing its part in creating an atmosphere of undestanding, sympathy and hope for the families of alcoholics and for the alcoholic. At this time in history, it looks as if the revolution in public attitudes about families of alcoholics which is now underway will be just as great as the attitude change about the alcoholic has been.

IS COMPULSORY TREATMENT of the ALCOHOLIC EFFECTIVE?

BY MORRIS E. CHAFETZ, M.D.

DIRECTOR, ALCOHOL CLINIC
MASSACHUSETTS GENERAL HOSPITAL

COMPULSION of any sort is a foreign concept in Western societies, especially in the United States and Canada. We despise totalitarian political systems, and we easily toss off slogans that contain the word "free" or "freedom." We have a judicial system designed theoretically to protect the freedom of those accused of crime, and certainly the current medical battleground centering around medical care for the aged is receiving major impetus from the American Medical Association because it stresses this bill will interfere with the freedom implicit in our present day doctor-patient relationships.

Of course, the judicial protection afforded the supposed psychotic being forced into a treatment setting he may not desire is a well-established practice. Because the designation of alcoholic or alcoholism is not as sharp a break or as easily discernible a deviant behavior as a psychosis can be, legislatures have been reluctant to include alcoholics under state commitment laws. Ambivalence has been the rule toward the alcoholic unless the complication of psychosis or other more diagnosable conditions exist with the alcoholism.

Reluctance toward even forcing treatment upon the diagnosed alcoholic is, of course, a reflection in part of historical influences. In our recent past we placed our drunkards in the stocks, tossed them into jail, coerced them onto prison farms, and called this corrective. When failure inevitably ensued, we concluded correctly that punitive measures were valueless, and those of us who became interested in the plight of alcoholics became self-righteous and indignant at the thoughts of enforced treatment.

More recently, however, there are those who do not necessarily share these views, since investigator after investigator has reported favorably (by and large) on the use of various forms of compulsion in the treatment of alcoholism in different settings such as industry, probation, court referrals, prisoners and com-

mitments to mental hospitals.

Let us, then, look at some of the necessary baselines for understanding alcoholism and the effectiveness of compulsory treatment. We take for granted the label "alcoholism" and yet in reality we have great difficulty defining its boundaries. We have, for example, little knowledge of alcoholism's natural history, little knowledge as to its cause and few reliable criteria for measuring therapeutic change. In most research reports on alcoholism there is the implicit and explict assumption that the diagnosis of alcoholism would be universally agreed upon and the results thereby are generalized to all alcoholics. Our group has extensively examined the literature evaluating treatment response in alcoholism and finds that authors provide little definition of criteria for diagnosis; little definition of variables being tested or controlled; and almost no definition of measures of change.

The issue is further complicated by the implication that there exists a special personality make-up of individuals suffering alcohol-related conditions which permit the label "alcoholic." I do not have to tell this audience that there is no universal definition of alcoholism; no specific, unifying set of personality traits. Furthermore, when authors write about treatment results, they seem unaware of the methodological difficulties involved when they contend that their introduced therapeutic procedure is the cause of subsequent change.

In measuring change and thereby examining effectiveness of treatment a pretherapeutic baseline must be assessed; definition, reliability, and validity of measures of change should be established, control groups should be an integral part of all attempts to test effectiveness of treatment in alcohol-related conditions.

Unfortunately, reports of studies in treatment with alcohol-related conditions have relied heavily on qualitatively defined categories, such as "improved" and "unimproved" and so on. Rare is the author who will spell out the operational definitions of his qualitative terms; rare is the reporter who tells us how the judgments were made. Not alone is little said about reliability of judgments, but no concern is voiced about possible artifacts in evaluation. The investigator seems least inclined to question the validity of his judgments and, apparently, there exists a distinct and unfortunate tendency to accept therapists' and/or patients' statements about therapeutic change and effectiveness as being the ultimate in validity. Unfortunately, with time and repetition, these statements of treatment effectiveness assume unwarranted conviction and we are engulfed with the dogmas of alcoholism therapies: give conditioned therapy, psychotherapy, antabuse, milieu treatment and so forth.

Now we all know that valid, relevant sources of data are not easy to come by. But there is also no question that many of the inadequacies of treatment outcome evaluation can be remedied. For

Compulsory treatment may be seen as merely one more technique in our armamentarium of tools for enhancing the motivation and needs we assume to exist in the alcoholic.

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example, besides collecting the statements of therapists and patients, we can cross check them with relatives and friends. Further, we can categorize a wide variety of life experiences such as occupational change, marriage, death of a relative, change in residence, and so forth, which may have an effect on change during the course of treatment. Variables of change, operationally defined and hence amenable to reliability study, can be developed. Now the most obvious relevent variable of change for alcohol-related conditions is change in drinking behavior. Please note that I have not said "abstinence," but change in drinking behavior.

For certain alcoholics, a meaningful, indirect measure of change in drinking behavior not subject to distortion is change in patterns of arrest and imprisonment for drunkenness. Another for certain alcoholic subgroup is change in patterns of hospitalization for sobering up or as a consequence of drinking. A third measure for change in drinking patterns can be established by measuring patterns of work days and absenteeism. I do not wish to imply that these objective measures of change are solely of import in the evaluation of therapeutic outcome, but rather that by combining these measures with the statements of the patients, their relatives and others close to the patient, and by a system of cross checking, the evaluator may derive more reliable evidence of change.

All of these measures of change, however, will bear little significance unless the definitions and measures are related to the question of pretherapeutic levels of functioning adjustment. A word of caution: the evaluation of treatment effectiveness using the patient as his own control may lead to a conclusion that a certain percentage of patients improve as a result of a therapeutic endeavor. Since we do not know how many patients with alcohol-related conditions spontaneously improve (it has been reported that one

We must constantly be of ridding ourselves of an

out of three patients with neuroses improve without any treatment), we may draw highly erroneous conclusions about our treatment effectiveness. In our own work, using the patient as his own control, we found that after treatment of 100 experimental patients, their rate of arrest had been greatly reduced. We could have concluded that as a result of our therapeutic approach, a striking reduction resulted in our patients' difficulties with the law. However, when we analyzed 100 comparison patients who had not received our special approach, we found that they, too, showed a similarly significant reduction in arrests. Further study revealed that both groups were drawn from a population of patients who are being less frequently arrested now than in the past.

Crucial to measuring change are follow-up procedures for long periods to gather material to assess effectiveness of treatment. Only after activity where pretherapeutic levels have been assessed, multiple measures of change have been used, and follow-up has been at a significant level is one relatively justified in generalizing findings of change.

Let us now look at the compulsory aspect in the title of my paper. We must immediately ask ourselves does any patient seek treatment without some inner or outer force pushing him into treatment? The answer is, obviously, of course not. We like to hang on to the myth of free action and freedom of choice, but how much do we really do without coercion? The cries against conformity bear me out; the sameness of our cities, homes, and dress do also, but I shall not belabor the point.

What I believe the assigners of my title had in mind is a legally enforced treatment; or the removal of freedom of movement by hospitalization. Even with

eminded that the use of compulsion may be another way nnoying problem in the guise of good care.

this narrow focus we must be on guard. The history of doing harm to people on the credo of doing them good is too fresh in many minds. We must constantly be reminded that our behavior as caretakers has not always been positively directed toward alcohol-related conditions and the possibility of using compulsion may be another way of ridding ourselves of an annoying problem in the guise of good care. Punitive treatment because of and for the caretaker can never be condoned. Forcing a patient into treatment when it has been determined to be for the good of the patient after careful examination and evaluation by a team is another matter. I may be able to give you a concrete example of what I mean.

For years we have noticed that a considerable number of individuals with alcohol problems had frequent, numerous readmissions ranging from 30-50 admissions to our emergency service. The attitude of the caretaker was that these were well-known patients. Closer examination revealed, however, that these patients were not, in fact, known—no one had completely evaluated them—but they were often seen. When careful evaluation was made and they were really known, these patients showed us that they were a group of individuals who presented themselves to a variety of community resources asking for help. The plea for help was not understood. The pleas were for external controls. These patients intuitively recognized their inability to deal with their own impulses and the society about them. Shunned, stunned and ostracised they wended their way from agency to agency, draining resources, creating feelings of anger and hopelessness. And yet all they asked, if someone took the time to really listen, was that external controls be applied. No better patient can you find than these when under cover; no more difficult when on the outside. We know these men require a hospital that will give their life structure and control, useful endeavors and treatment, and the necessary society where they can survive. In our enlightened community such facilities do not yet exist. When they do, a large population of neglected patients—neglected in terms of their needs, not neglected because they are hopeless—will be helped. These people need a compulsory form of treatment; at our present stage of knowledge, no other form will do.

There are other areas of patient need that can be met by forms of compulsory treatment. For some patients, applying the attitude that they **must** undergo treatment, after a careful evaluation has been made, means someone is interested in them. Too often we caretakers have offered our various treatments on a take-it-or-leave-it basis. Our work on motivating alcohol patients into treatment has clearly demonstrated that if the patient does not come for or stay in treatment the fault may lie with the caretaker or his approach, or his lack of understanding of the needs of the individual. This is why I always stress that we should discard our stereotyped images that there is an alcoholic and we have the treatment he must fit to. Rather, we should view the daily problems as one of an individual who, as one manifestation of his problems, has an alcohol-related condition and how, after careful study, can we provide a treatment program that fits his needs and the resources available. You can readily see how for certain patients compulsory treatment would be necessary and effective.

This latter point leads me to a discussion of treatment goals in determining effectiveness. Now if abstinence is your main measure of treatment effectiveness

and the other factors of the patient's well-being—functioning, self-respect and interpersonal relations are—of lesser import, then, sole compulsion by incarceration can lead to abstinence. Incarcerate patients, see they have no supply of alcohol and they will be abstinent and you can report your treatment is effective. But I hope such parochial punitive goals do not motivate this audience. The goals of treatment must be consistent with the patient's potential and resource, as well as with the facilities society can offer him to achieve his goals. As a researcher you have seen how I have suggested setting up measures and we can use then our carefully described criteria for effectiveness. We can say the patient has been effectively treated when he has had X number of days, months, years of symptom freedom, and then call it a therapeutic triumph. If a relapse occurs after the set period, we can consider this the advent of a new, separate illness. The model I use is that of the method used for the study of cancer, i.e., five years of no recurrence or relapse, the patient is cured. Cancer thereafter is considered a new lesion.

The reason for suggesting this is that very often we set up goals in treatment, achieve them, and after a successful period, a relapse occurs and the treatment is considered a failure. This leads to discouragement and despair and statements that alcohol problems are not successfully treated.

As a clinician I don't have this problem. If the patient changes for the better for a time, regardless of who or what is responsible, then my efforts are worthwhile. For example, if I treat, as a clinician, a patient who consumes a fifth of liquor per day and, after treatment, he drinks only two shots per day instead, that is improvement. If I can get the patient who has not worked, not had interpersonal relations and been intoxicated daily to be sober and functioning for thirty days, this is worthwhile. Perhaps this is all the patient can tolerate for change, and this may be all my therapies are able to accomplish.

The relation between setting limits in psychotherapy and compulsory treatment, as I see it, is that both setting limits and compulsory treatment offer the individual a choice. This offering of a choice is further related to the important question of civil liberties and compulsory treatment. If treatment is indeed compulsory (in the sense of a prison sentence after all appeal has been exhausted), I am against it. I am against laws which state that an alcoholic **must** enter treatment. The element of choice, clearly pointed out to the individual, must be present. For example, the judge who wishes to commit an alcoholic to a treatment program must offer jail or treatment; not just treatment alone.

Civil Liberties

Our group has just had to face this problem of civil liberties versus enforced treatment in a project designed to attempt to elucidate early signals of alcoholism in a population of young people ordinarily not referred for treatment. It was the contention of the National Institute of Mental Health review committee, the state agencies involved, and our research group that regardless of the importance of the project, every effort must be made to protect the rights of the individual even against efforts for his own good. I cannot emphasize this latter point enough.

Therefore, in closing our perusal of compulsory treatment in alcoholism it would appear that we are left with the sense, if we are to protect and guard the rights of the individual, that compulsory treatment may be seen as merely one more technique in the caretaker's armamentarium of tools for enhancing the motivation and needs we assume to exist in alcoholics. We must protect the patient not only from himself, but often from those who want to care for him as well.

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ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

We can help our youth grow in maturity and become responsible, mature individuals by assisting them in the development of an inner sense of security.

Protection Against Alcohol Problems

BY REVEREND ROLAND RAINWATER

This article originally appeared in the first edition of *Alcoholics Are God's Children, Too,* published by the North Carolina Alcoholic Rehabilitation Program.

IF you had completed a talk on the subject of alcohol before a group of college students and immediately were asked, "What is the most important thing we can do about the problem?" how would you have replied? Once asked this question in such a situation, I answered: "Become as mature as possible so you can be mature parents."

Whatever the merit of this reply, it suggests what I deem as our primary aim in working with youth in church and synagogue: to assist them in their growth toward maturity. By **assist** I mean support which is based on the understanding of youth as particular persons whose behavior is the outgrowth of forces and needs of environment and personality, offered with discrimination and skill. By **maturity** I mean that kind of individuality which is characterized by real freedom and responsibility in one's motivation as well as behavior, and which is also consistent with the individual's age, endowment, and experience.

But the freedom and responsibility with which one conducts himself is dependent upon basic inner security. And it is in helping our youth establish within themselves a solid foundation that we are often ineffective. This is at least partly due to an invalid assumption often underlying our work. It is the idea that our principal task is to impart certain inherited or adult-endorsed views on alcohol, or some other issue of concern, and to get them assented to by our young people, believing that their assent marks the completion of our mission. This assumption rests upon a superficial understanding of the learning process and of the relation of truth in the inner life.

With the significance of one's inner security in mind, we must study carefully the behavior of our teen-agers because it is the sign which points to the state of things in the individual's inner life.

In this connection we shall be raising such questions as these: What causes him repeatedly to withdraw when responsibility is offered him? Why is he so very eager to please? Why is he commonly hostile when there is no apparent or immediate reason? Why is he such a nuisance? These questions should stir us to want to know young people better and to find ways for doing so, while looking toward opportunities for helping them to confront their needs constructively. As our experience here widens, a larger vision of our work develops, with the result that personal relationships assume deeper meaning for us because of their significance for the inner security and growth of persons.

The 14-year-old boy I once knew illustrates what is in view here. He was the behavior problem in his class at the public school, church school, and among his peers. He seriously interfered with the undertaking of the group around him and in time was ostracized by classmates. Upon investigation I found that he was attractive in appearance, very intelligent, versatile in his interests, and from a home of refinement and material advantage. "With such assets, why should he be a problem?" I asked myself. On further inquiry I learned that one thing he most needed he had been deprived of—the feeling that he was acceptable as a person of real value by one who held special meaning in his life.

His father, during the crucial years of his son's childhood and early adolescence, had been so preoccupied with achieving the standard of financial success he coveted for his family and himself that he had not been available to give his son the associations of love which only a father can give. Therefore, shorn of this ingredient so basic to his well-being, the son turned to nuisance behavior by which to gain attention. This behavior, being obnoxious to others, instead of bringing him a sense of acceptance, only enhanced his feeling of unacceptableness (deprivation of love) deep within him—an awareness that led him even more desperately to seek attention by being more of a nuisance.

Back of the personalities of teenagers is the tension which is peculiar to human existence and is at the center of human growth. I refer to the condition created as the result of one's desire on the one hand to be an individual and on the other to conform to the wishes and practices of those in his environment. If we are sensitive to the underlying pull of these two poles of growth, we can be more understanding and effective in relating to our young people and in the planning of a program. We can thereby grasp the need for a particular approach to the individual or group on one occasion and the wisdom of a different tactic at another time, while being steadily aware that our role is one of helping individuals to strike a balance between individuality and conformity.

Significance of Peer Group

This tension is especially important in the years of adolescence on account of the general pattern that growth takes in this period. As we well know, teenagers are bent upon severing every tie with childhood's necessary dependencies and restrictions. Increasingly, they look for security outside the home; hence, what peers are thinking and doing is of growing importance. It is thus quite natural for a young person to accuse his parents of being "too hard on me" or "not understanding" when they withhold permission for him to participate in an activity of his gang or group. Of course, he may or may not be justified, depending upon the wisdom of his parents. The relevant point here is the significance he attaches to his peer group, resulting in an increasing preference for the approval (acceptance) of peers over that of parents.

In view of this characteristic zeal for independence of family and acceptance by peers, it is obviously the course of prudence to avoid as often as possible tactics of programming which to the teen-ager constitute a threat to his freedom as a person and to his standing among peers. As a rule, the methods which can be expected to be most effective will be those which are positive in account and appeal to the adolescent's desire for freedom and responsibility.

As an example of this approach on the level of group activity, I cite the move-

ment known as Allied Youth. The aim of this organization is the encouragement of regular social activity among high school students without the use of alcohol. As a body of youth they have the strength of standing together as mutually approved persons in resisting the drinking pattern of the community, whereas as individuals apart from such a group their resistance would be more difficult and likely less effective. And in their opposition to the prevalent drinking pattern at social functions for their age, these young people do not withdraw from the activities but merely decline to drink. Plainly much of the vitality of this movement is due to its positive note and its regard for the integrity of both the individual and his peers.

I have suggested the need for helping youth to become mature individuals—that is, free and responsible persons. And I have assumed that this development occurrs within the network of inter-personal relations. We become who we are because of and in relation to others. For this reason the various activities—recreation, parties, work projects, study, discussion, and worship—which compose our program for young people should foster deeper understanding and acceptance of young persons, and provide the nourishment required for growth in freedom and responsibility. In this way these activities are viewed as media by which further growth toward maturity is possible.

One of the unfortunate oversimplifications of the problem of alcohol is the view that its solution consists in propagandizing in the interest of an intellectual commitment, be it for abstinence or temperance. Individuals repeatedly have resolved intellectually to abstain or to be moderate, only later to discover they had taken a drink or become intemperate. Why? The primary reason I believe to have been the lack of adequate support for conscious commitment in the unconscious depths of one's being. Hence the answer to such repeated failure lies not in further resolutions of the conscious mind, but in removing unconscious blocks to the conscious mind's commitment. What is needed is as much integration of the inner life as possible—its conscious and unconscious aspects—so that a particular commitment, such as abstinence or temperance, may be wholehearted rather than partial.

Unfortunately, however, the change necessary in the depths of one's being is not as easily achieved as an alteration of conscious mind. Exposure to facts over a brief duration may result in a radical reorientation of mind on the conscious level. But on the unconscious level more complexity is involved.

For example, if one has had unstable and threatening (destructive) personal relationships during the early years of his life he is likely to feel more than average insecurity as a teen-ager. Accordingly, his need for group approval is likely to be more pronounced; and likewise if his peers invite him to drink, though intellectually he may be committed to abstinence, he is more likely to do so because, being unusually insecure, he craves (unconsciously) the partial security which acceptance by his peers affords him.

Basic Feeling of Security

On the other hand, if one has experienced relationships which have established within him a basic feeling of security, he is more likely, everything else being equal, to confront the pressures of teen-age life in normal stride. He has the foundation for being more rational, for greater freedom in resisting or submitting to the various tides of influence which roll in upon him. Of course, the fact that his life rests on this foundation is no guarantee that he will act responsibly in a given situation. There are the factors of environment and heredity, and the peculiar needs of personality in the teen years, that complicate the matter.

In such instances the significance of security, or its absence, is readily apparent. To the extent it is present the individual has the basis for personal freedom and in proportion to its absence real freedom is impossible. And this deep sense of security is achieved only through security-producing relationships. Conversely, the profound insecurity one may experience is the result of personal relationships which are essentially destructive in their effect upon the individual's inner life.

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**Alcohol Information Center;* Mike Dechman, Educational Director; Parkway Offices; Phone: ALpine 3-7567.

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BURLINGTON—

**Alamance County Council on Alcoholism;* Margaret Brothers, Executive Director; Room 802, N. C. National Bank Building; Phone: 228-7053.

‡*Outpatient Clinic;* Alamance County Hospital; Hours: Wed., 9:00 a.m.-4:00 p.m.

BUTNER—

‡*Aftercare Clinic;* John Umstead Hospital; Hours: Mon.-Fri., 9:00 a.m.-4:00 p.m.

CHAPEL HILL—

†*Alcoholism Clinic of the Psychiatric Outpatient Service;* N. C. Memorial Hospital; Phone: 942-4131, Ext. 336.

**Orange County Council on Alcoholism;* Dr. D. D. Carroll, Director; 102 Laurel Hill Rd.

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**Charlotte Council on Alcoholism;* Rev. Joseph Kellermann, Director; 1125 E. Morehead St.; Phone: FRanklin 5-5521.

‡*Mecklenburg Aftercare Clinic;* 1200 Blythe Blvd.; Hours: Mon.-Fri., 8:00 a.m.-5:00 p.m.

†*Mental Health Center of Charlotte and Mecklenburg County, Inc.;* 1200 Blythe Blvd.; Phone: FRanklin 5-8861.

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†*Cabarrus County Health Department;* Phone: STate 2-4121.

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**Greensboro Council on Alcoholism;* Worth Williams, Executive Director; 216 W. Market St., Room 206 Irvin Arcade; Phone: 275-6471.

†*Guilford County Mental Health Center;* 300 E. Northwood St.; Phone: BRoadway 3-9426.

†*Family Service Agency;* 1301 N. Elm St.

‡*Outpatient Clinic;* 300 E. Northwood St.; Hours: Mon. and Thurs., 5:00-10:00 p.m.

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†*Pitt County Mental Health Clinic;* Pitt County Health Department, P. O. Box 584; Phone: PLaza 2-7151.

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JAMESTOWN—

**Alcohol Education Center;* Ben Garner, Director; P. O. Box 348; Phone: 883-2794.

LAURINBURG—

**Scotland County Citizens Committee on Alcoholism;* M. L. Walters, Executive Secretary; 308 State Bank Bldg.; Phone: 276-2209.

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SANFORD—

†*Mental Health Clinic of Sanford and Lee County, Inc.;* 106 W. Main St.; P. O. Box 2428; Phone: 775-4129 or 755-4130.

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†*Cleveland County Mental Health Clinic;* 101 Brookhill Rd.; Phone: 482-3801.

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‡*Aftercare Clinic;* Encas Station; Hours: Mon.-Fri., 8:00 a.m.-5:00 p.m.

†*Wilson County Mental Health Clinic;* Encas Rural Station; Phone: 237-2239.

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**†Alcoholism Program of Forsyth County;* Marshall C. Abee, Executive Director; 802 O'Hanlon Bldg., 105 W. 4th St.; Phone: PArk 5-5359.

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